STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 01 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/27/11 Facility Number: 004671 Provider Number: 155742 AIM Number: 200538760 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, St. Andrews Health Campus was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 108 and had a	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 01 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	census of 78 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 05/31/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			
K0029 SS=E	Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 Based on observation and interview, the facility failed to ensure the 1 of 12 hazardous areas, such as a kitchen was provided with a self closing door. This deficient practice could affect any residents who use the main dining room, located adjacent to the kitchen. Findings include: Based on observation on 05/27/11 at 12:10 p.m. with the director of physical plant operations, the west kitchen door had a one inch gap with the door closed and the door failed to latch into the door frame on three separate attempts. Based	K0029	The Door exiting the kitchen, the frame has been readjusted for proper closure and latching. Director of Plant Operations will monitor and make adjustments as needed for poper closure.	06/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 01 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	on an interview with the director of physical plant operations on 05/27/11 at 12:20 p.m., the west kitchen door frame is broken and won't allow the door to self close and latch. 3.1-19(b)			
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on record review and interview, the facility failed to ensure 1 of 1 battery backup lights was tested at 30 day intervals and annually for a 90 minute duration to ensure the light would provide lighting during periods of power outages to protect any resident using the main dining room. LSC 18.2.9.1 requires emergency lighting shall be provided in accordance with Section 7.9. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents in the facility during a period of power outage. Findings include:	K0046	A log sheet has been implemented to document the monthly test for the emergency battery back up light. This log will also show the annual 90 minute duration test. The Director of Plant Operations will conduct these monthly and annually.	06/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155742	A. BUILDING 01 B. WING	05/27/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANDREWS HEALTH CAMPUS	1400 LAMMERS PIKE BATESVILLE, IN47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on an interview on 05/27/11 at 10:20 a.m. with the director of physical plant operations, the facility has one battery backup light located in the main electrical/emergency generator transfer switch room. Based on a review of the Preventive Maintenance Log Book on 05/27/11 at 10:20 a.m. with the director of physical plant operations, there was no evidence the battery powered backup light was tested at thirty day intervals or annually for a ninety minute duration. This was verified by the director of physical plant operations at the time of record review. 3.1-19(b)			